

FILED FEB 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

3475

00041

BIRTH NO.		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>2254</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Koch (rural)</u>)		c. LENGTH OF STAY (in this place) <u>532 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>25</u> OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>914 North 18th St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>							
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Thomas</u>		b. (Middle) <u>J.</u>		c. (Last) <u>Stack</u>	
4. DATE OF DEATH		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	
8. DATE OF BIRTH <u>9-1-00</u>		9. AGE (In years last birthday) <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John J. Stack</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Stack</u>		14. NAME OF HUSBAND OR WIFE (deceased) <u>Helene Ford Stack</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>075-05-9077</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital Records, Robt. Koch Hosp.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>??</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-23-49</u> , 19 <u>49</u> , to <u>1-6-50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>1-6-50</u> , 19 <u>50</u> , and that death occurred at <u>5:45A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>J. W. Beckham, M.D.</u>		(Degree or title) <u>D</u>		23b. ADDRESS <u>Robert Koch Hospital</u>		23c. DATE SIGNED <u>1-6-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>JAN-9-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-7-50</u>		REGISTRAR'S SIGNATURE <u>Herbert P. Domko</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E. J. Schum 3125 Lafayette</u>			

(Licensed Embalmer's Statement of Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____, Student Embalmer No. _____,
working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.